TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Garland

Respondent Name
Accident Fund General Insurance

MFDR Tracking Number
M4-14-1305-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
January 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received preauthorization for the requested codes 97110, 97112, and 97140 per Rule 134.600 one preauthorization is give the carrier shall not withdraw a preauthorization or concurrent review approval. It also does not specify a unit or code max on the preauthorization letter."

Amount in Dispute: $203.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No written response submitted by Carrier.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2013	97140, 97110	$203.52	$87.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 119 – Benefit maximum for this time period or occurrence has been reached. 28 Texas Administrative Code §134.600 (n) states in pertinent part, "The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented." Review of the submitted documentation finds;

    a. Document from Coventry dated August 28, 2013: Procedure – Physical Therapy 2xWk x 5Wks, Left Ankle 97110 97112 97140, Quantity – 10 Physical Therapy, Date of Service 08/28/13 10/4/13

    The Carrier's denial is not supported and there was no "limits" placed on the number of units for each modality billed. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)." The maximum allowable reimbursement is calculated as follows;

    - Procedure code 97140, service date September 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.43387. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.017 is 0.44748. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.88969 is multiplied by the Division conversion factor of $55.30 for a MAR of $49.20. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.

    - Procedure code 97110, service date September 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.

3. The total allowable reimbursement for the services in dispute is $193.11. This amount less the amount previously paid by the insurance carrier of $105.12 leaves an amount due to the requestor of $87.99. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $87.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $87.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May 19, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.